FROM THE DIRECTOR

Col Patricia C. Lewis

If you're looking for helpful hints to prepare for a Health Services Inspection, you may want to query the HSI Trends Analysis on the AFIA Medical Operations web site. The site includes Active Duty and Air Reserve Component inspection results for CY 00, 01 and 02 by element. There are five files in all; files one, three and five contain data specific to a CY: File four is a trend summary report with the same data provided in the previous files but displayed by MAJCOM, peer group, ANG and ARC and file three is a summary report of high findings.

I know this sounds confusing, but once you pull up any one of the files you'll find the information displayed in an easy to read format. Take the first file as an example; this file contains a list of all 160 elements, element number and descriptive title. If an element was scored during an HSI in CY 02 (Jan-Jun) then the number of findings, Type I, II and element comment, is provided following the descriptive title. There is a similar file for CY 01 and 00 results. These files are the basis for the briefing material provided in the second file, Summary of High Findings. The summary report for CY 01 is currently on the web site, CY 02 will be posted in Dec 02. This particular file is what we use to brief the Inspector General and Surgeon General at the semiannual summit.

The Summary of High Findings file is a PowerPoint briefing of those elements with the most findings for that year. For every frequent finding identified, the top four or five discrepancies noted by the inspector are listed, as well as a recommendation for resolution. For the most part, these discrepancies can be "fixed" at the MTF level. However, there are those programs/processes that are broken across the Air Force Medical Service thus requiring assistance from a higher level.

The information provide by the HSI Trend Analysis tool should prove useful as part of your self-assessment program. And taking that extra step to include the crosstalk articles and inspection aids, also provided on the AFIA web site, should only improve your self-assessment program and increase your chances for a successful inspection.

Root Cause Analysis--Improper Management of Training Affiliation Agreements

Col Tywana Bowman

Improper coordination and preparation of Training Affiliation Agreements (TAA) in Air Force Medical Treatment Facilities (MTF) continues to be a common discrepancy during Health Services Inspections (HSI). There were significant improvements during FY 02; however, there are opportunities for increased compliance. This article will briefly disclose the results of a root cause analysis (RCA) conducted on the HSI element, TAAs and will also provide recommendations for managing TAAs

Let's begin with results of the RCA. The two common HSI discrepancies for TAAs were as follows. First, the MTF failed to obtain approval from HQ/USAF/SGWM Human Resource Division, prior to implementation of the TAA. Secondly, training programs were not properly reviewed for continuation. A knowledge deficit and lack of executive oversight were major contributing factors to the discrepancies. Unfortunately, improper oversight of TAAs could result in medicolegal or financial liability for the MTF and negatively impact overall training opportunities.

The simple antidote for correcting these HSI discrepancies is to follow the Air Force Instructions. The remainder of this article will provide a brief orientation to the purpose of TAAs and introduce available resources to assist in establishing and maintaining a TAA.

The United States Air Force MTFs have generously contributed to the professional mentoring and clinical training for civilian training agency students. For example, advanced students in nursing, pharmacy, medical, laboratory training or massage science studies generally require some 'on-the-job' experience prior to graduation. Conversely, the civilian educational agencies provide the MTF with well-trained and motivated individuals who augment services provided to our beneficiaries. The students enter the medical treatment facilities to practice with an experienced health care provider in their career field and prepare to function independently after graduation. In these situations, the TAA is a tool that ensures all involved agencies (the Air Force Medical Service, the medical facility, the civilian training agency and the student) are involved in the planning and approval process. Thus, the beneficiaries receive optimum health care in a carefully structured environment.

The recommended format, content, language and approval authorities for TAAs are outlined in AFI 41-108, *Training Affiliation Agreement Program*. Strict adherence to this guidance will ascertain that all medical, legal, practice and insurance issues are appropriately addressed. Not until the document has received HQ Air Force (HQ USAF/SGWM) approval is the administrative approval process complete and the agreement ready for activation. The TAA revalidation is accomplished at least once

every 3 years and the new document is submitted to SGWM if there are changes. If there are absolutely no changes to the document, SGWM is to be so advised.

Corporate-level nuances of the TAA process include periodic MTF program evaluation, MTF executive leadership oversight and periodic program assessment with the civilian agency. The most successful program managers schedule the reviews annually in the work center functional meetings as a recurring agenda item. The annual TAA program review is recorded in the work center functional meeting minutes and forwarded to the executive level through the organizational review process.

Managing TAAs is a multifaceted task. The pre-activation phase takes a large investment of time; however, once initiated, the TAA program upkeep is relatively simple. The endowment of mentoring to new professionals, increased services to beneficiaries and personal satisfaction to the preceptors are all well worth the effort.

Air Reserve Component (ARC) Infection Control

Major Dana Smith

This article is written from a Health Services Inspections (HSI) perspective specifically for ARC units. Failure to meet basic requirements resulted in 43 ARC units receiving a total of 32 write-ups during HSIs in 2001. Twenty-one of the discrepancies were from element OPS.3.4.4., *Infection Control Program-Structure and Organization.*

The basic requirements for managing Infection Control programs are described in AFI 44-108, *Infection Control Program.* Occupational Safety and Health Administration (OSHA) regulations and the Centers for Disease Control and Prevention also play a significant role in this unit-wide program along with other instructions and regulatory agency guidance. One can find additional applicable references at the end of the HSI element. The Joint Commission on Accreditation of Healthcare Organizations evaluates the active duty units and the HSI team evaluates infection control programs at the air reserve component units.

The first area of concern is the lack of required plans. Several units did not have or only recently implemented annual infection control plans, a tuberculosis exposure control plan or a bloodborne pathogen exposure control plan. These plans are the "meat and potatoes" of how organizations actively help prevent and control infections among patients, staff and visitors. Lack of local guidance could potentially put medical units at undue risk for exposure and negatively impact the unit's readiness capabilities.

The second area of concern is the lack of required infection control program oversight. In a few instances, an infection control committee (ICC)/infection control review function (ICRF) was not in place nor did they consistently meet quarterly as required. In other instances, aerospace medicine squadrons (AMDS) or their local equivalent did not ensure facility exposure control plans were developed, reviewed or updated. This responsibility falls under AMDS or a local equivalent as the executor of the occupational health program. The ICC/ICRF by design should be a multidisciplinary group that coordinates all activities related to the surveillance, prevention and control of infections. Lack of appropriate program oversight could put both internal and external customers at risk.

The third area of concern is training and education. The infection control officer or their designated ICC/ICRF chairperson had not received required training. Units can improve and better meet the intent of the program by ensuring that their infection control officer and their designated chairperson attend a training course in epidemiology and infection control no later than 1 year after being assigned to the position, assuming they have not received equivalent training elsewhere.

The school at Sheppard Air Force Base offers a convenient 1-week course for ARC members. The class holds up to 15 students and is offered numerous times throughout

the year. Information about the course is found on the following website https://www.afms.mil/school/frames.html. The AFI offers some civilian alternatives to the classes offered at Sheppard that might better accommodate the member's schedule. However, be aware that classes offered at Sheppard have a military focus that civilian courses might not.

Finally, the most important way to help improve one's compliance is to conduct an initial self-inspection of the infection control program with follow-ups as needed. Typically, self- inspections are based on the most current HSI guide and the most current AFI. The status of your self-inspections should be reported as required by your organization. The two infection control inspection elements will be combined into one in the 2003 HSI guide, so be sure to review the changes. Hopefully, this brief review will give ARC units some helpful tips on improving their programs.

UPDATE ON SELF-AID AND BUDDY CARE (SABC)

Lt Col Danita McAllister and Lt Col John Wiseman

For many of our medical treatment facilities (MTFs), policy changes in the HQ USAF/IL, memo dated 15 Nov 01, presented new opportunities to work with line counterparts in preparing for possible contingencies related to weapons of mass destruction (WMD). Along with those opportunities came questions about how to implement the new requirements. Some issues remain under discussion, such as procedures for maintenance of WMD installation first responder projects, while others, including SABC, have been clarified.

Previously, clinicians were exempt from SABC training, although they were required to receive Wound Care and Casualty Management training annually if assigned to a deployable UTC. Nonclinician medical personnel assigned to deployable UTCs were required to receive standard SABC training biennially. These training percentages were reported monthly in the Status of Resource and Training System (SORTS) (reference Atch 3 and Para 5.6 of AFI 41-106, Medical Readiness Planning and Training). The general rule was only those assigned to deployable UTCs were required to complete the Wound Care and Casualty Management/SABC.

The HQ USAF/IL memo mandated that ALL military personnel receive SABC training, including nonclinical personnel referenced in AFI 41-106, Para 5.5.11., and those not assigned overseas or assigned to mobility positions. Since medical personnel already received training unique to their clinical backgrounds, this change generated questions about what portions of SABC training were needed for each medical AFSC. HQ USAF/SGX clarified this with their memo dated 2 Apr 02. Clinicians are now required to complete Wound Care and Casualty Management and the bandaging/splinting and manual carriers portion of the formal SABC program regardless of their deploy ability. All other medical personnel must complete SABC regardless of their deploy ability. Attachment 8 of AFI 41-106 lists all medical AFSCs and designates each as “clinical” or “nonclinical” for use in determining required training.

Throughout this past summer, base SABC advisors should have coordinated with all base units (both host and tenant) to establish or evaluate unit SABC programs, trained new unit SABC instructors as needed and provided technical advice to wing leadership in support of the HQ USAF/IL policy letter. Medical unit SABC monitors should have implemented a process to ensure training for all medical personnel (and those nonmedical personnel assigned to the unit) in accordance with the HQ USAF/SGX policy letter. Medical IG inspectors will be closely evaluating compliance with these policies and Medical Readiness Staff Function oversight of the SABC program.